TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Health System

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2284-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 29, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on their payment of $0, the APC and therapy allowable due is of $9,088.50 on the APC alone, at this time. We had to submit the medical records and item twice to the carrier and they have now denied this for past the filing deadline when the initial submission on 1/12/2017 was in fact within the time frame."

Amount in Dispute: $9,088.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined the ESIS Med Bill Impact will stand on the original recommendation of $0.00. Their original billing (our DCN 32733559) was received on 5/24/16 and was denied for missing medical records. Their second billing (our DCN 33386798) was received on 8/24/16 and again denied for missing medical records. The third billing (our DCN 9646791) was received on 3/7/17. This was denied as not having submitted the reconsideration with 10 months from the date of service. We have no proof of a corrected billing containing all medical records being received prior to the 10 month cutoff."

Response Submitted by: ESIS 1851 E 1ST St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2016 through April 1, 2016	Outpatient Hospital Services	$9,088.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out requirement for billing documentation.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 188 – Please submit a copy of the report and the bill for our review
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - FIR – Further information required
   - 338 – Submission for reconsideration is no later than 10 months from the date of service
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 29 – The time limit for filing has expired
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - W3
   - CIQ378 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services for dates of service March 30, 2016 through April 1, 2016.

   The insurance carrier denied disputed services on June 1, 2016 with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

   28 Texas Administrative Code §133.210 requires that (a) (b) (c) states

   a. Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

   b. When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

   c. In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

      (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

      (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

      (3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;

      (4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and

      (5) for hospital services: an itemized statement of charges.

The request for medical fee dispute contained a second explanation of benefits dated March 14, 2017 that also contained adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

The requestor states, "We had to submit the medical records and item twice to the carrier and they have now denied this for past the filing deadline when the initial submission on 1/12/2017 was in fact within the time frame."

However, the Division found insufficient evidence to support that either with the initial bill or at the point of reconsideration that the required elements of 28 Texas Administrative Code §133.210 (a) (c) (2) (5) were submitted and received by the carrier. Therefore, the carrier's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		April 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.